Sean M. Cerone, D.D.S., P.A.

Family, Cosmetic & Implant Dentistry

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us -- we will be happy to help.

1. Personal Information

Date _____

Birthdate _____

SS#/SIN _____ Email _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/Province _____ Zip/P.C. _____

Employer _____ Occupation _____

Referred by _____

2. Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License _____

SS#/SIN _____ Email _____

Address _____

City _____ State/Province _____ Zip/P.C. _____

Employer _____ Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3. Telephone

Home Phone _____ Cell Phone _____

Work Phone _____ Ext # _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Work Phone _____ Home # _____

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4. Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Insured's Birthdate _____	Insured's Birthdate _____
SS#/SIN _____	SS#/SIN _____
Employer _____	Employer _____
Date Employed _____	Date Employed _____
Insurance Company _____	Insurance Company _____
Insurance Phone # _____	Insurance Phone # _____
Group # _____	Group # _____
Employee/Cert. # _____	Employee/Cert. # _____
Ins. Co. Address _____	Ins. Co. Address _____
Deductible _____	Deductible _____
Amount already used _____	Amount already used _____
Max. annual benefit _____	Max. annual benefit _____

5. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor Date

6. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

_____ Cash
_____ Personal Check
_____ Credit Card _____ Visa _____ MC
_____ I wish to discuss the dental office's policy

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank You

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask -- we are always happy to help.

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HEALTH HISTORY

Name _____ Birthday _____ Today's Date _____

A. Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

	YES	NO
5. Do your gums bleed while brushing?	☐	☐
6. Do your gums bleed when flossing?	☐	☐
7. Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
9. Have you noticed any loosening of your teeth?	☐	☐
10. Does food tend to become caught between your teeth?	☐	☐
11. Do you have any sores or lumps in or near your mouth?	☐	☐
12. Have you ever experienced any of the following problems in your jaw?	☐	☐
a. Clicking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐

	YES	NO
13. Have you had any head, neck, or jaw injuries?	☐	☐
14. Do you have frequent headaches?	☐	☐
15. Do you clench or grind your teeth while awake or asleep?	☐	☐
16. Do you bite your lips or cheeks frequently?	☐	☐
17. Have you ever had:	☐	☐
a. Orthodontic treatment (braces)?	☐	☐
b. Oral surgery?	☐	☐
c. Gum treatment?	☐	☐
d. Your teeth ground or the bite adjusted?	☐	☐
e. Worn a bite plane or other appliance?	☐	☐
18. Are you satisfied with the appearance of your teeth?	☐	☐
19. Have you ever had an upsetting experience in the dental office?	☐	☐
20. Is there anything about having dental treatment that bothers you?	☐	☐

B. Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health within the past year?	☐	☐
3. Date of your last physical exam: _____		
4. Physician's name: _____		
Address: _____		
Phone #: _____		
5 Are you now under the care of a physician?	☐	☐
6 Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Please explain: _____		
_____		
7 Are you taking any medicine(s), including non-prescription medicine?	☐	☐
If yes, what medicine(s) are you taking? _____		
_____		
8. Have you ever taken Fen-Phen/Redux?	☐	☐

	YES	NO
9. Have you had any abnormal bleeding?	☐	☐
10. Do you bruise easily?	☐	☐
11. Have you ever required a blood transfusion?	☐	☐
12. Have you had a recent weight loss?	☐	☐
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
14. Do you use tobacco?	☐	☐
15. Do you use alcohol?	☐	☐
16. Do you use other recreational drugs?	☐	☐
17. Are you wearing contact lenses?	☐	☐
18. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

Women Only:

1. Are you pregnant or think you may be pregnant?	☐	☐
2. Are you nursing?	☐	☐
3. Are you taking birth control pills?	☐	☐

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C. Medical History Continued…

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin or other antibiotics?	☐	☐
3. Sulfa drugs?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐
5. Aspirin?	☐	☐
6. Iodine?	☐	☐
7. Other?_____	☐	☐
Do you have or have your ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet Fever?	☐	☐
3. Heart defect or heart murmur?	☐	☐
4. Heart trouble, heart attack, or angina?	☐	☐
a. Do you have pain in your chest upon exertion?	☐	☐
b. Are you ever short of breath afte mild exercise?	☐	☐
c. Do your ankles swell?	☐	☐
d. Do you get short of breath when you lie down?	☐	☐
e. Do you require extra pillow when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐
8. Low blood pressure?	☐	☐
9 Hepatitis, jaundice or liver disease?	☐	☐
10. Stroke	☐	☐
11. Sinus trouble?	☐	☐
12. Lung or breathing problems?	☐	☐
13. Asthma or hay fever?	☐	☐
14. Hives or skin rash?	☐	☐
15. Fainting spells or seizures?	☐	☐
16. Diabetes?	☐	☐
17. AIDS or HIV infection?	☐	☐
18. Thyroid problems?	☐	☐
19. Allergies?	☐	☐
20. Arthritis or rheumatism?	☐	☐
21. Joint replacement or implant?	☐	☐
22. Stomach ulcer?	☐	☐
23. Kidney trouble?	☐	☐
24. Tuberculosis?	☐	☐
25. Persistent cough?	☐	☐
26. Cough that produces blood?	☐	☐
27. Cancer?	☐	☐
28. Sexually transmitted disease?	☐	☐
29. Epilepsy?	☐	☐
30. Anemia?	☐	☐
31. Leukemia?	☐	☐
32. Glaucoma?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

For Completion by the Dentist:

SUMMARY OF DENTAL HISTORY

_____

_____

_____

_____

SUMMARY OF MEDICAL HISTORY

_____

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS PATIENT	DENTIST	HYGIENIST
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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271 E. Southlake Blvd. Ste 150
Southlake, TX 76092

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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271 E. Southlake Blvd. Ste 150
Southlake, TX 76092

We understand that sometimes circumstances arise that prevent patients from keeping appointments. (It happens to the best of us!) It is office policy to charge patients a $25.00 fee for broken appointments. In the future, if you find it impossible to keep an appointment, please give us a call 24 hours in advance. With this notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you.

We request this courtesy because it allows us to see our patients promptly. It also helps us provide more affordable dental care for all of our patients.

I certify that I have read this agreement and understand this office's appointment policy and agree to the terms.

Signature _____ Date: _____